KY Medicaid

MMIS Batch Health Care Professional Health Care Claim And Encounter Claims (837P) Companion Guide

Version 3.3_FINAL

Cabinet for Health and Family Services
Department for Medicaid Services

November 19, 2012

(DMS Approved 11/19/2012)

Companion Guide Version 3.3_FINAL
Version 005010 X222A1

Document Change Log

Version	Changed Date	Changed By	Reason
2.0	11/02/2011	Kathy Dugan	Removed NTE Segment Instructions
2.1	12/22/2012	Martha Senn	Atypical provider id updates
2.2	2/1/2012	Martha Senn	Inserted Encounter usage for 2300B NM101 – NM109 page 25. Final version, DMS approved on 02/01/2012.
2.3	6/21/2012	Martha Senn	Inserted MCO SBR clarifications in section 1.1.1 Special Considerations as #14; comment inserted at 2000B & 2320 SBR segments to reference Special Considerations.
3.0	10/21/2012	Kathy Dugan	Added NM101 and NM102 in Loop 2010BB to be consistent with 837I and 837D Companion Guides on page 17. Added new data elements, REF01 and REF02 in Loop 2010BB on Page 18
3.1	10/24/2012	Keri Hicks	Updates
3.2	11/19/2012	Martha Senn	Added K3 segment for denied details on page 28 Added Region ‘09’ to 2010BB REF on page 18
3.3	11/19/2012	Keri Hicks	Updates

Table of Contents

1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) require that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://www.cms.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/content/view/817/1

1.1 Purpose

The 837 Professional Transactions is used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic professional claim submissions to the Commonwealth of Kentucky. The intent is to expedite the goal of achieving a totally electronic data interchange environment for health care encounter/claims processing, payment, corrections and reversals. This transaction will support the submission of professional claims, professional encounters, and Coordination of Benefits for Medicare Part B. The 837 Professional is the electronic correspondent to the paper CMS-1500 claim form; therefore, any claim types or encounter data submitted on the CMS-1500 form correlate to the 837 Professional, if data is submitted electronically.

All required segments within the 837 Professional Transaction Set must always be sent by the submitter and received by the payer. Optional information will be sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments in the incoming transaction may not be used during claims processing, some of these data elements will be returned in other transactions such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

1.1.1 Special Considerations for 837 Professional Transaction

1. **Subscriber, Insured = Member in the Kentucky Medicaid Eligibility Verification System:**

The Commonwealth of Kentucky Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/members are primary subscribers within each program or MCO (Managed Care Organization)';

2. Provider Identification = Commonwealth of Kentucky Medicaid ID or NPI:

As of May 23, 2008, KY Medicaid does not allow use of the *Kentucky Medicaid* provider IDs (atypical is exempt); only NPI is permitted on any inbound or outbound transaction;

3. Taxonomy:

Billing Provider taxonomy at Loop 2000A is required when the payer's adjudication is known to be impacted by the provider taxonomy code;

Rendering Provider, taxonomy at Loop 2310B applies to the entire claim unless overridden on the service line level at Loop 2420A;

4. **Atypical Providers:**

Providers classified as an 'atypical provider' are excluded from NPI and taxonomy and continue to use their legacy ID. The following provider types are considered Atypical Providers:

- Hands;
- Non-emergency Transportation;
- Commission for Handicapped Children;
- Title V/DSS;
- First Steps; and,
- Impact Plus.

NOTE: The Legacy ID MUST be submitted in Loop 2010BB, REF – BILLING PROVIDER SECONDARY IDENTIFICATION.

5. **Logical File Structure:**
   There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE); however, the functional groups must be the same type;

6. **Submitter:**
   Submissions by non-approved trading partners will be rejected;

7. **Claims and Encounters:**
   Claims and encounters must be submitted in separate ISA/IEA envelopes;

8. **Response/999 Acknowledgement:**
   A response transaction will be returned to the trading partner that is present within the ISA06 data element.
   Commonwealth of Kentucky will provide a 999 Acknowledgment for all transactions that are

received.
You will receive this acknowledgment within 48 hours unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for a request type transaction, i.e. 270 or 276, you will receive the appropriate response transaction generated from the request. If the transaction submitted was a claim transaction, i.e. 837, you will receive either the 835 or the unsolicited 277.

NOTE The 835 and unsolicited 277 are only provided weekly;

9. **Claims Allowed per Transaction (ST/SE envelope):**
The HIPAA implementation guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments.
Commonwealth of Kentucky does not have a maximum for the number of claims per transaction (ST/SE envelope);

10. **Document Level:**
Commonwealth of Kentucky processes files at the claim level. It is possible based on where the error(s) occur within the hierarchical structure that some claims may pass compliance and others will fail compliance. Those claims that pass compliance are processed within the Medicaid Management Information System (MMIS). Those claims that fail compliance are reported on the 999;

11. **Dependent Loop:**
For Commonwealth of Kentucky, the subscriber is always the same as the patient (dependent). Data submitted in the Patient Hierarchical Level (2000C loop) are ignored;

12. **Compliance Checking:**
Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. All other levels are validated within the MMIS;

13. **Identification of TPL:**
For each claim at the header level, if loop 2320 (Other Subscriber Information) is present and SBR09 (Claim Filing Indicator) is not equal to Medicare, the COB Payer Paid Amounts (AMT01=D) received in the 2320 loop(s) will be summed together for the Payer Paid Amount.

NOTE The 2320 loop can repeat multiple times per claim;

14. Subscriber information:

Loop 2000B SBR01 –MCO's must send the value of S if one other payer is submitted in Loop 2320. If two payers paid value of T should be sent. If three payers paid value of A should be sent, continue up to ten payer's submitted in Loop 2320 value G should be sent.

Example: 2000B SBR01 value = S

2320 SBR01 value = P if Medicare paid SBR09 value MA or MB

2320 SBR01 value = T MCO SBR09 value = HM

Example: 2000B SBR01 value = T

2320 SBR01 value = P if commercial insurance payer 1 paid SBR09 value = CI

2320 SBR01 value = S if Medicare paid SBR09 value MA or MB

2320 SBR01 value = A MCO SBR09 value = HM

Loop 2320B SBR01 – The MCO will always be the highest payer with value H if ten other payers paid.

Loop 2320 SBR09 – MCO will always send HM.

15. File Naming Standards:

1.2 (837P/I/D/NCPDP)

- 837P – Professional;
- 837I – Institutional;
- 837D – Dental; and,
- NCPDP – Pharmacy.

16. **(TPID) – 10 digit Trading Partner ID**
(O/R/A/V)

- O – Original (new claims);
- R – Resubmission (claims that have been billed before but did not process for some reason);
- A – Adjustment (adjustments to existing claims);
- V – Void (voids for both 837 and pharmacy); and,
- D – Denied.

17. K3 – File Information

- Loop 2400 K3 - MCO must use this segment with the value of A1 for all paid professional claims with denied details

2 CONTROL SEGMENT DEFINITIONS FOR KENTUCKY MEDICAID 837 PROFESSIONAL TRANSACTION

X12N EDI Control Segments
➢ ISA – Interchange Control Header Segment ➢ IEA – Interchange Control Trailer Segment ➢ GS – Functional Group Header Segment ➢ GE – Functional Group Trailer Segment ➢ ST – Transaction Set Header ➢ SE – Transaction Set Trailer ➢ TA1 – Interchange Acknowledgement

2.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
C.4	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
C.4	N/A	ISA	ISA02 - Authorization Information	[space fill]
C.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
C.4	N/A	ISA	ISA04 - Security Information	[space fill]
C.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined
C.4	N/A	ISA	ISA06 - Interchange Sender ID	'ID Supplied by KY Medicaid' – Sender ID
C.5	N/A	ISA	ISA07 - Interchange ID Qualifier	'ZZ' – Mutually Defined
C.5	N/A	ISA	ISA08 - Interchange Receiver ID	'KY Medicaid' – Receiver ID
C.5	N/A	ISA	ISA09 - Interchange Date	The date format is YYMMDD
C.5	N/A	ISA	ISA10 - Interchange Time	The time format is HHMM
C.5	N/A	ISA	ISA11 - Repetition Separator	'^' – Repetition Separator

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
C.5	N/A	ISA	ISA12 - Interchange Control Version Number	'00501' – Control Version Number
C.5	N/A	ISA	ISA13 - Interchange Control Number	Interchange Unique Control Number – Must be identical to the interchange trailer IEA02
C.6	N/A	ISA	ISA14 - Acknowledgment Requested	'1' – Acknowledgement Requested
C.6	N/A	ISA	ISA15 – Interchange Usage Indicator	'T' - Test Data 'P' - Production Data
C.6	N/A	ISA	ISA16 - Component Element Separator	':' – Component Element Separator

2.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
C.10	N/A	IEA	IEA01 - Number of included Functional Groups	Number of included Functional Groups
C.10	N/A	IEA	IEA02 - Interchange Control Number	Must be identical to the value in ISA13

2.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
C.7	N/A	GS	GS01 - Functional Identifier Code	'HC' – Health Care Claim (837)
C.7	N/A	GS	GS02 - Application Sender's Code	This will be equal to the value in ISA06, the KY Medicaid 8 or 10 digit provider ID.
C.7	N/A	GS	GS03 - Application Receiver's Code	This will be equal to the value in ISA08, 'KYMEDICAID' and 5 spaces.
C.7	N/A	GS	GS04 - Date	The date format is CCYYMMDD
C.8	N/A	GS	GS05 – Time	The time format is HHMM
C.8	N/A	GS	GS06 - Group Control Number	Group Control Number
C.8	N/A	GS	GS07 - Responsible Agency Code	'X' – Responsible Agency Code
C.8	N/A	GS	GS08 - Version/Release/ Industry Identifier Code	'005010X222A1' – Version / Release / Industry Identifier Code

2.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
C.9	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
C.9	N/A	GE	GE02 – Group Control Number	Must be identical to the value in GS06

2.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
70	N/A	ST	ST01 – Transaction Set Identifier Code	'837' – Health Care Claim
70	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number
70	N/A	ST	ST03 – Implementation Convention Reference	'005010X222A1' – Version / Release / Industry Identifier Code Must be identical to the value in GS08

2.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
496	N/A	SE	SE01 – Number of Included Segments	Total Number of Segments included in Transaction Set Including ST and SE.
496	N/A	SE	SE02 – Transaction Set Control Number	Must be identical to the value in ST02

2.7 TA1 – Interchange Acknowledgement

The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure. TA1 Structure can be found in the ASC X12N 837 (004010X098) Implementation Guide.

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.11	N/A	TA1	TA101 - Interchange Control Number	Interchange control number of the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA102 - Interchange Date	The date format is YYMMDD Date within the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA103 - Interchange Time	The time format is HHMM Time within the original interchange received (ISA/IEA)
B.12	N/A	TA1	TA104 - Interchange Acknowledgement Code	'A' – Transmitted interchange control structure header/trailer received without errors. 'E' – Transmitted interchange control structure header/trailer received and accepted, errors are noted. 'R' – Transmitted interchange control structure header/trailer rejected due to

837 Professional Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
				errors.
B.12	N/A	TA1	TA105 - Interchange Note Code	See Implementation Guide for valid values

2.8 Valid Delimiters for Kentucky Medicaid EDI

Definition	ASCII	Decimal	Hexadecimal
Segment Terminator	~	126	7E
Data Element Separator	*	42	2A
Compound Element Separator	:	58	3A
Repetition Separator	^	94	5E

3 Companion Guide for the 837P Transaction

Page	Loop	Segment	Data Element	Comments
Header				
71	N/A	BHT	BHT01 – Hierarchical Structure Code	'0019' – Information Source, Subscriber, Dependent
71	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
72	N/A	BHT	BHT03 – Originator Application Transaction Identifier	The inventory file number of the transmission assigned by the submitter's system. This number operates as a batch control. This field is limited to 30 characters.
72	N/A	BHT	BHT04 – Transaction Set Creation Date	This is the date the original submitter created the claim file from their business application system. Format = CCYYMDD
72	N/A	BHT	BHT05 – Transaction Set Creation Time	This is the time the original submitter created the claim file from their business application system. Format = HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD
72	N/A	BHT	BHT06 - Transaction Type Code	'CH' – Chargeable (Use with Professional Health Care Claim) 'RP' – Reporting (Use with Professional Health Care Encounter)
Submitter Name				
74	1000A	NM1	NM101 – Entity Identifier Code	'41' - Submitter

Page	Loop	Segment	Data Element	Comments
75	1000A	NM1	NM102 – Entity Type Qualifier	'1' – Person '2' – Non-Person Entity
75	1000A	NM1	NM103 – Name Last or Organization Name	Required but not used in processing
75	1000A	NM1	NM104 – Name First	Required when NM102 = 1 Not used in processing
75	1000A	NM1	N M105 – Name Middle	Required when NM102 = 1 Not used in processing
75	1000A	NM1	NM108 – Identification Code Qualifier	'46' – Electronic Transmitter Identification Number
75	1000A	NM1	NM109 - Identification Code	Kentucky Medicaid assigned EDI Trading Partner ID
77	1000A	PER	PER01 – Contact Function Code	'IC' – Information Contact
77	1000A	PER	PER03 - Communication Number Qualifier	'TE' – Telephone 'EM' – Electronic Mail 'FX' – Fax
77	1000A	PER	PER05 – Communication Number Qualifier	'EM' – Electronic Mail 'EX' – Telephone Extension 'FX' – Facsimile 'TE' - Telephone
78	1000A	PER	PER06 – Communication Number	
78	1000A	PER	PER07 – Communication Number Qualifier	'EM' – Electronic Mail 'EX'- Telephone Extension 'FX' – Facsimile 'TE' – Telephone
Receiver Name				
79	1000B	NM1	NM101 – Entity Identifier Code	'40' – Receiver Entity ID
79	1000B	NM1	NM102 – Entity Type Qualifier	'2' Non-Person Entity

Page	Loop	Segment	Data Element	Comments
80	1000B	NM1	NM103 – Name Last or Organization Name	'KYMEDICAID'
80	1000B	NM1	NM108 – Identification Code Qualifier	'46' – Electronic Transmitter Identification Number (ETIN)
80	1000B	NM1	NM109 - Identification Code	'KYMEDICAID'
Billing Provider Hierarchical Level				
81	2000A	HL	HL01 – Hierarchical ID Number	The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01
81	2000A	HL	HL03 – Hierarchical Level Code	'20' – Information Source
82	2000A	HL	HL04 – Hierarchical Child Code	'1' – Additional Subordinate HL Data Segment in this Hierarchical Structure.
Billing Provider Specialty Information				
83	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider.
83	2000A	PRV	PRV02 - Reference Identification Qualifier	'PXC' – Health Care Provider Taxonomy Code
83	2000A	PRV	PRV03 - Reference Identification	This is the Billing Provider's 10 Digit Taxonomy Code' Do Not Send if the Billing Provider is an Atypical Provider
Billing Provider Name				
88	2010AA	NM1	NM101 – Entity Identifier Code	'85' – Billing Provider
88	2010AA	NM1	NM102 – Entity Type Qualifier	'1' – Person '2' – Non-person Entity
89	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Centers for Medicare and Medicaid Services National Provider Identifier (NPI) for Healthcare Providers

Page	Loop	Segment	Data Element	Comments
90	2010AA	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider Do Not Send if the Billing Provider is an Atypical Provider. Send Legacy ID in REF02 with REF01 = G2 in Loop 2010BB
Billing Provider Address				
91	2010AA	N3	N301 – Billing Provider Address Line	Billing provider Address Line must be a street address. Post Office Box or Lock Box, addresses are to be sent in the Pay-To Address Loop (Loop ID-2010AB), if necessary. Required but Kentucky Medicaid will not use in processing
91	2010AA	N3	N302 – Billing Provider Address Line	Required when there is a second address line. Kentucky Medicaid will not use this in processing.
Bill Provider City, State, Zip Code				
92	2010AA	N4	N401 – Billing Provider City Name	Billing Provider City Name
93	2010AA	N4	N402 – Billing provider State or Province Code	Billing Provider State
93	2010AA	N4	N403 – Billing Provider Postal Zone or ZIP Code	Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks)
Billing Provider Tax Identification				
94	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – Employer's Identification Number or 'SY' – Social Security Number of the provider.
94	2010AA	REF	REF02 - Billing Provider Tax Identification Number	9 digit Employer's Identification Number or Social Security Number.

Page	Loop	Segment	Data Element	Comments
96	2010AA	REF	Billing Provider UPIN/License Information	REF Segment will be accepted but will not be used in processing or stored in MMIS
Billing Provider Address				
Billing Provider City, State, Zip Code				
92	2010AA	N4	N401 – City Name	Billing Provider City Name
93	2010AA	N4	N402 – State or Province Code	Billing Provider State
93	2010AA	N4	N403 – Billing Provider Postal Zone or ZIP Code	Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks)
Billing Provider Tax Identification				
94	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – Employer's Identification Number or SY – Social Security Number of the provider
94	2010AA	REF	REF02 - Reference Identification	9 digit Tax Identification Number or 9 Digit Social Security Number
Billing Provider UPIN/License Information				
96	2010AA	REF	REF – Billing Provider UPIN/License Information	REF Segment will be accepted but will not be used in processing or stored in MMIS.
Billing Provider Contact Information				
99	2010AA	PER	PER01 – Contact Function Code	'IC' – Information Contact
99	2010AA	PER	PER03 – Communication Number Qualifier	'EM' – Electronic Mail 'FX' – Facsimile 'TE' – Telephone
99	2010AA	PER	PER05 – Communication Number Qualifier	'EM' – Electronic Mail 'EX' – Telephone Extension 'FX' – Facsimile 'TE' - Telephone
100	2010AA	PER	PER07 – Communication Number Qualifier	'EM' – Electronic Mail

Page	Loop	Segment	Data Element	Comments
				'EX' – Telephone Extension 'FX' – Facsimile 'TE' - Telephone
Subscriber Hierarchical				
Note: For Commonwealth of Kentucky, the subscriber is always the same as the patient (2000B SBR02=18, SBR09=MC). Claims containing data in the 2000C Patient Hierarchical Level (i.e. Dependent) will be processed using only the subscriber data.				
114	2000B	HL	HL01 – Hierarchical ID Number	'1' - Additional Subordinate HL Data Segment in this Hierarchical Structure.
115	2000B	HL	HL03 – Hierarchical Level Code	'22' – Subscriber
115	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure '1' – Additional Subordinate HL Data Segment in this Hierarchical Structure.
Subscriber Information				
116	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	A- Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility Eleven P –Primary S –Secondary T –Tertiary U - Unknown **See section 1.1.1 Special Clarification #14 for MCO usage.*
117	2000B	SBR	SBR02 – Individual Relationship Code	'18' – Self
118	2000B	SBR	SBR09 - Claim Filing Indicator	'MC' - Medicaid

Page	Loop	Segment	Data Element	Comments
			Code	
Patient Information				
119	2000B	PAT	PAT05 – Date Time Period Format Qualifier	'D8' – Date Expressed in Format CCYYMMDD
120	2000B	PAT	PAT07 – Unit or Basis for Measurement Code	'01' – Actual Pounds
120	2000B	PAT	PAT09 – Yes/No Condition or Response Code	'Y' – Yes 'N' – No
Subscriber Name				
121	2010BA	NM1	NM101 – Entity Identifier Code	'IL' – Insured or Subscriber
122	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
122	2010BA	NM1	NM103 – Subscriber Last Name	
122	2010BA	NM1	NM104 – Subscriber First Name	
122	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
123	2010BA	NM1	NM109 - Identification Code	'10 digit' - Kentucky Medicaid Member Identification Number (MAID)
127	2010BA	DMG	DMG01 - Date Time Period Format Qualifier	"D8" - Date Expressed in Format CCYYMMDD
128	2010BA	DMG	DMG03 – Subscriber Gender Code	"F" Female "M" Male "U" Unknown
Payer Name				
133	2010BB	NM1	NM101 - Entity Identifier Code	'PR' Payer
134	2010BB	NM1	NM102 - Entity Type Qualifier	'2' Non-Person Entity
134	2010BB	NM1	NM103 - Name Last or Organization Name	'KYMEDICAID'
134	2010BB	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
134	2010BB	NM1	NM109 - Identification Code	'KYMEDICAID'

Page	Loop	Segment	Data Element	Comments
138	2010BB	REF	REF01 – Reference Identification Qualifier	'FY – Claim Office Number This data element is required by KY Medicaid
139	2010BB	REF	REF02 – Reference Identification	Submit the Member Region in this data element. '01', '02', '03', '04', '05', '06', '07', '08', '09','31' This data element is required by KY Medicaid
140	2010BB	REF	REF01 – Reference Identification Qualifier	G2 – Provider Commercial Number Use for atypical providers
141	2010BB	REF	REF02 – Reference Identification	Legacy KY Medicaid provider id of the atypical provider.
Claim Information				
158	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Control Number Length allowed: 1 to 38. The value received will be returned on the 835 transaction.
159	2300	CLM	CLM02 – Total Claim Charge Amount	Total Billed Charge Max Length 10 with decimals Max Length 8 with whole numbers 99999999.99 99999999
159	2300	CLM	CLM05-2 – Facility Code Qualifier	'"B" - Place of Service Codes for Professional or Dental Services
159	2300	CLM	CLM05-3 - Claim Frequency Type Code	Refer to Implementation Guide for Valid Values
194	2300	REF	REF01 - Reference Identification Qualifier	'G1' – Prior Authorization Number
195	2300	REF	REF02 - Reference Identification	Assigned Prior Authorization Number

Page	Loop	Segment	Data Element	Comments
196	2300	REF	REF01 - Reference Identification Qualifier	"F8" Original Transaction Control Number (TCN)
196	2300	REF	REF02 - Reference Identification	FFS: Original KY Medicaid Internal Control Number (ICN) MCO: Original MCO Assigned Internal Control Number
208	2300	K3	K301 - Fixed Format Information	'MCO Receipt Date – Format CCYYMMDD' Required for MCO Encounters
209	2300	NTE	NTE01 - Note Reference Code	'ADD' - Additional Information
210	2300	NTE	NTE02 - Claim Note Text	'Physician Assistant Number'
223	2300	CRC	CRC01 – EPSDT Code Category Qualifier	"ZZ" Mutually Defined EPSDT Screening referral information.
224	2300	CRC	CRC02 - Certification Condition Code Applies Indicator	The response answers the question: Was an EPSDT referral given To the patient? "N" No If no, then choose "NU" in CRC03 indicating no. Referral given. "Y" Yes
224	2300	CRC	CRC03 – Condition Indicator	The codes for CRC03 also can be used for CRC04 through CRC05 "AV" Available - Not Used

Page	Loop	Segment	Data Element	Comments
				Patient refused referral. "NU" Not Used This conditioner indicator must be used when the Submitter answers “N” in CRC02. "S2" Under Treatment Patient
224	2300	CRC	CRC04 – Condition Indicator	
225	2300	CRC	CRC05 – Condition Indicator	
226	2300	HI	HI01-1	"BK" International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis
228	2300	HI	HI02-1	"BF" International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis
229	2300	HI	HI03-1	"BF" International Classification of Diseases Clinical Modification (ICD
230	2300	HI	HI04-1	"BF" International Classification of Diseases Clinical Modification (ICD
231	2300	HI	HI05-1	"BF" International Classification of Diseases Clinical Modification (ICD
232	2300	HI	HI06-1	"BF" International Classification of Diseases Clinical Modification (ICD
233	2300	HI	HI07-1	"BF" International Classification of Diseases Clinical Modification (ICD
234	2300	HI	HI08-1	"BF" International Classification of Diseases Clinical Modification (ICD

Page	Loop	Segment	Data Element	Comments
235	2300	HI	HI09-1	"BF" International Classification of Diseases Clinical Modification (ICD
236	2300	HI	HI10-1	"BF" International Classification of Diseases Clinical Modification (ICD
237	2300	HI	HI11-1	"BF" International Classification of Diseases Clinical Modification (ICD
238	2300	HI	HI12-1	"BF" International Classification of Diseases Clinical Modification (ICD
Referring Provider Name (KenPAC or Lock-in)				
258	2310A	NM1	NM101 – Entity Identifier Code	'DN' – Referring Provider Use on the first iteration of this loop. Use if loop is used only once. "'P3" – Primary Care Provider Use only if loop is used twice. Use only on second Iteration of this loop.
259	2310A	NM1	NM108 - Identification Code Qualifier	"XX" – Centers for Medicare and Medicaid Services National Provider Identifier (NPI) for Healthcare Providers.
259	2310A	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider.
Rendering Provider Name				
263	2310B	NM1	NM101 - Entity Identifier Code	'82' – Rendering Provider
264	2310B	NM1	NM108 - Identification Code Qualifier	'XX' – Centers for Medicare and Medicaid Services National Provider Identifier (NPI) for Healthcare Providers. **Atypical Providers Do Not**

Page	Loop	Segment	Data Element	Comments
				Send This Data Element
264	2310B	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider. **Atypical Providers Do Not Send This Data Element**
265	2310B	PRV	PRV01 - Provider Code	'PE' – Performing
265	2310B	PRV	PRV02 - Reference Identification Qualifier	'PXC' – Health Care Provider Taxonomy
265	2310B	PRV	PRV03 - Reference Identification	Provider Taxonomy Code
267	2310B	REF	REF01 - Reference Identification Qualifier	KY will only accept G2 for processing (see definitions of values)
268	2310B	REF	REF02 - Reference Identification	**For Atypical providers only.** Use 8 or 10 digit Medicaid Provider ID
Other Subscriber Information				
296	2320	SBR	SBR01 – Payer Responsibility Sequence Number Code	A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility Eleven P - Primary S - Secondary T – Tertiary U –Unknown **See section 1.1.1 Special Clarification #14 for MCO usage.*
297	2320	SBR	SBR03 - – Insured Group or Policy Number	

Page	Loop	Segment	Data Element	Comments
297	2320	SBR	SBR05 – Insurance Type Code	"12" Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan "13" Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan "14" Medicare Secondary, No-fault Insurance including Auto is Primary "15" Medicare Secondary Worker's Compensation "16" Medicare Secondary Public Health Service (PHS)or Other Federal Agency "41" Medicare Secondary Black Lung "42" Medicare Secondary Veteran's Administration "43" Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) "47" Medicare Secondary, Other Liability Insurance is Primary
298	2320	SBR	SBR09 – Claim Filing Indicator Code	"11" Other Non-Federal Programs "12" Preferred Provider Organization (PPO) "13" Point of Service (POS) "14" Exclusive Provider Organization (EPO) "15" Indemnity Insurance "16" Health Maintenance

Page	Loop	Segment	Data Element	Comments
				Organization (HMO) Medicare Risk "17" Dental Maintenance Organization "AM" Automobile Medical "BL" Blue Cross/Blue Shield "CH" Champus "CI" Commercial Insurance Co. "DS" Disability "FI" Federal Employees Program "HM" Health Maintenance Organization "LM" Liability Medical "MA" Medicare Part A "MB" Medicare Part B "MC" Medicaid "OF" Other Federal Program Use code OF when submitting Medicare Part D claims. "TV" Title V "VA" Veterans Affairs Plan "WC" Workers' Compensation Health Claim "ZZ" Mutually Defined *Use Code ZZ when Type of Insurance is not known.*
301	2320	CAS	CAS02 – Adjustment Reason Code Also CAS05, CAS08, CAS 11, CAS14,	All external code source values from code source 139 are allowed.

Page	Loop	Segment	Data Element	Comments
			CAS17	All denied encounters must submit value 'A1'.
301	2320	CAS	CAS03 – Adjustment Amount	Adjustment Amount For denied encounters this amount will equal the Total Charge Amount in CLM02 in Loop 2300
301	2320	CAS	CAS05 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
302	2320	CAS	CAS08 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
302	2320	CAS	CAS11 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
303	2320	CAS	CAS14 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
304	2320	CAS	CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
305	2320	AMT	AMT01 - Amount Qualifier Code	'D' – Payer Amount Paid
305	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (TPL, MCO and Medicare) Used for Fee-for-Service and Encounters
306	2320	AMT	AMT01 - Amount Qualifier Code	'A8' – Non-covered Charges - Actual
306	2320	AMT	AMT02 - Non-Covered Charge Amount	Non-Covered Charges Amount
307	2320	AMT	AMT01 – Amount Qualifier Code	'EAF' – Amount Owed
307	2320	AMT	AMT02 – Remaining Patient Liability	Remaining Patient Liability
Other Payer Name				
Note: 2330B DTP or 2430 DTP segment required for Medicare and Encounters. 2330B REF				

Page	Loop	Segment	Data Element	Comments
segment required for Encounters.				
320	2330B	NM1	NM101 – Entity Identifier Code	'PR' - Payer
320	2330B	NM1	NM102 – Entity type Qualifier	'2' – Non-Person Entity
321	2330B	NM1	NM103 – Other Payer Last or Organization Name	
321	2330B	NM1	NM108 – Identification Code Qualifier	'PI' – Payer Identification
321	2330B	NM1	NM109 – Other Insured Payer Primary Identifier	**For ENCOUNTER only.** Use MCO or Passport 10 digit trading partner ID when NM101 PR represents MCO or Passport as the payer.
325	2330B	DTP	DTP01 - Date Claim Paid	'573' - Other Payer, Medicare or MCO Claim Adjudication Date
325	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
325	2330B	DTP	DTP03 – Adjudication or Payment Date	TPL, Medicare or MCO Adjudication Date (CCYYMMDD)
331	2330B	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
331	2330B	REF	REF02 - Reference Identification	Other Payer's Claim Control Number
Service Line				
352	2400	SV1	SV101-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
355	2400	SV1	SV103 – Unit or Basis for Measurement Code	"MJ" Minutes Required for Anesthesia claims. Anesthesia time is counted from the moment that the practitioner, having completed the preoperative evaluation, starts an

Page	Loop	Segment	Data Element	Comments
				intravenous line, places monitors, administers pre-anesthesia sedation, or otherwise physically begins to prepare the patient for anesthesia. Time continues throughout the case and while the practitioner accompanies the patient to the post-anesthesia recovery unit (PACU). Time stops when the practitioner releases the patient to the care of PACU personnel. "UN" Unit
355	2400	SV1	SV105 - Facility Code Value	Reference the KY Medicaid Billing Instructions
356	2400	SV1	SV107-1 – Diagnosis Code Pointer	This first pointer designates the primary diagnosis for this service line. Remaining diagnosis pointers indicate declining level of importance to service line. Acceptable values are 1 through 12, and correspond to Composite Data. Elements 01 through 12 in the Health Care Diagnosis Code. HI segment in the Claim Loop ID-2300.
356	2400	SV1	SV107-2 – Diagnosis Code Pointer	Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.
356	2400	SV1	SV107-3 – Diagnosis Code Pointer	Required when it is necessary to point to a third diagnosis

Page	Loop	Segment	Data Element	Comments
				related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.
356	2400	SV1	SV107-4 – Diagnosis Code Pointer	Required when it is necessary to point to a fourth diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.
357	2400	SV1	SV111 - Yes/No Condition or Response Code	If Disposition Code is 'Y' for EPSDT Services, information required in 2400 NTE02. See Section 4 – 3 of the Program specific required information for KY Medicaid claims processing.
411	2400	K3	K301 - Fixed Format Information	Use to report denied details This segment is in conjunction with the CAS segment for denied information
413	2400	NTE	NTE01 - Note Reference Code	'ADD' – Additional Information
413	2400	NTE	NTE02 - Description Time of Pick-up – Military Time	See Section 4 – 1 of the Program specific required information for KY Medicaid claims processing
413	2400	NTE	NTE02 - Description School Location Identifier	See Section 4 – 2 of the Program specific required information for KY Medicaid claims processing
413	2400	NTE	NTE02 - Description Number of Students – Employee ID	See section 4 – 4 of the Program specific required information for the KY

Page	Loop	Segment	Data Element	Comments
				Medicaid claims processing
413	2400	NTE	NTE02 - Description Employee ID	See section 4 – 5 of the Program specific required information for the KY Medicaid claims processing
413	2400	NTE	NTE02 - Description Referral Code – Vaccine Code	See section 4 – 6 of the Program specific required information for the KY Medicaid claims processing
414	2400	NTE	NTE01 – Note Reference Code	'TPO'
414	2400	NTE	NTE02 - Description Line Note Text	
425	2410	LIN	LIN03 – Product/Service ID	National Drug Code (NDC)
427	2410	CTP	CTP05-1 – Measurement Code for NDC	"F2" International Unit "GR" Gram "ME" Milligram "ML" Milliliter "UN" Unit
480	2430	SVD	SVD01 – Identification Code	Other Payer Primary Identifier
481	2430	SVD	SVD02 – Monetary Amount	Service Line Paid Amount
485	2430	CAS	CAS01 – Claim Adjustment Group Code	'PR' Patient Responsibility
486	2430	CAS	CAS02 – Claim Adjustment Reason Code	All external code source values from code source 139 are allowed. All denied encounters must submit value 'A1'. For Medicare recommend values are the following: '1' – Deductible '2' – Co-Insurance

Page	Loop	Segment	Data Element	Comments
486	2430	CAS	CAS03 – Monetary Amount	Adjustment Amount For denied encounters this amount will equal the Total Charge Amount in CLM02 in Loop 2300
486	2430	CAS	CAS04 – Quantity	Adjustment Quantity
490	2430	DTP	DTP03 – Date Time Period	Adjudication or Payment Date – Medicare paid

4 Program Specific Required Information for Kentucky Medicaid Professional Claims Processing

1. Transportation Providers must enter the required information in loop 2400 NTE02 data element (Previously billed in the 2300 NTE02):

   - Time of Pickup (Format is HHMM) Must be preceded by a qualifier of PT, (PTHHMM); and,
   - Location of Pickup and Destination Code within the new MMIS will be billed as a modifier. (Please see Transportation Billing Manual for valid Modifiers).

2. Preventive Care Providers who bill claims that require a seven position school ID must enter that number in loop 2400, NTE02 data element (Previously billed in the 2300 NTE02):

   - School Location Identifier: 7 position values must be preceded by a qualifier of ST, (STxxxxxxx).

3. All Providers billing Early Periodic Screening, Diagnosis and Treatment Procedures (EPSDT) must use disposition codes when abnormal conditions are found. Please refer to the Billing Instructions for the applicable disposition codes. The disposition codes must be placed in loop 2400 NTE02 data element:

   - Disposition Code: Each disposition code must be a length of 2. Up to 3 occurrences can be billed. Must be preceded by a qualifier of DC, (DCxxxxxx).

4. School-Based Health Service Providers who bill claims that require Number of Students or Number of Students and 3 positions Employee ID must enter those values in loop 2400, NTE02 data element. If Number of Students and Employee ID are submitted each value must be preceded by the appropriate qualifier and separated with a comma (,). If only sending Number of Students or Employee ID do not send the comma (,) after the data. Local modifier codes were also billed with the number of students for dates of service prior to 10/16/03. Local modifiers will not be used within the new MMIS.

   - Number of Students: Valid values 1-6, preceded by a qualifier of SB, (SBx);
   - Employee ID: 3 position value preceded by a qualifier of EI, (EIxxx);
     - Example of both values being billed: SBx,Eixxx; and,
     - Example of single value being billed: SB2.

5. Community Mental Health Center and Substance Abuse Providers who bill claims that require a 4 position Employee ID must enter that number in loop 2400, NTE02 data element :

   - Employee ID: 4 position value preceded by a qualifier of EI, (EIxxxx)

6. All Providers who bill claims that require “EPSDT Referral Codes” and/or “Vaccine Codes” must enter those values in loop 2400, NTE02 data element. If EPSDT Referral Codes and Vaccine Codes are submitted each must value be preceded by the appropriate qualifier and separated with a comma (,). If only sending EPSDT Referral Code or Vaccine Code do not send the comma (,) after the data.

- EPSDT Referral Codes: Each EPSDT Referral code must be a length of 2. Up to 3 occurrences can be billed. Must be preceded by a qualifier of RC, (RCxxxxxx);
- Vaccine Codes: Each Vaccine code must be a length of 2. Up to 3 occurrences can be billed. Must be preceded by a qualifier of VC, (VCxxxxxx);
    - Example of both values being billed: RCxx,VCxxxx; and,
    - Example of single value being billed: VCxx.